Patient Registration Form

You have been scheduled with WellStar Medical Group Oncology. We know your time is valuable; to make your visit as efficient as possible, this Patient Registration Form is needed by your physician at the time of your visit.

Please complete these forms as accurately as possible and bring them with you to your appointment. Your physician will need a complete list of medications you are taking, any allergies you may have and other history which may have an impact on your healthcare. This information will assist your physician in obtaining a complete picture of your medical, surgical and social history.

Completion of this information before your scheduled appointment will make your visit more efficient and the information provided will help you and your physician make the best healthcare decision possible.

We ask that you bring your insurance/pharmacy cards and picture ID.

Thank you,
WellStar Health System Medical Group Oncology

NORTHWEST GEORGIA ONCOLOGY CENTERS

Wellstar HEALTH SYSTEM
A Service of Wellstar Cobb Hospital

Patient Registration Form

NEW PATIENT HEALTH HISTORY FORM

Patient Last Name | Patient First Name | Date of Birth | Today's Date

Referring Physician | Other Physicians you see: | Other Physicians you see:

Reason for visit:

		Diagnosis Year			Diagnosis Year
High Blood Pressure	Y N		Kidney Problem	Y N	
Bypass/Valve Replacement	Y N		Stomach Problem	Y N	
Pacemaker or Defibrillator	Y N		HIV	Y N	
Congestive Heart Failure	Y N		Hepatitis	Y N	
Heart Attack / Rhythm Problem	Y N		Osteoporosis	Y N	
Thyroid Problem	Y N		Seizures	Y N	
Diabetes	Y N		Blood Clots	Y N	
Asthma or COPD	Y N		Prior history of Cancer	Y N	
Gout	Y N		Depression	Y N	

Other illness not listed above:

Prior Surgeries:

		Year			Year			Year
Gallbladder	Y		Spleen	Y		Colon	Y	
Uterus	Y		Lumpectomy	Y		Joint Replacement	Y	
Ovaries (one)	Y		Mastectomy	Y		Prostate	Y	
Ovaries (both)	Y		Stomach Bypass	Y				

Health Maintenance: Fill in all that apply.

		Date			Date
Colonoscopy	Y		Prostate Exam	Y	
Mammogram	Y		Pap Smear	Y	

Gynecologic History: Fill in all that apply.

First menstrual period age? Age | Last menstrual period (menopause) age? Age | Number of pregnancies?

Birth control pills Y N | Hormone replacement therapy? Y N

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NEW PATIENT HEALTH HISTORY FORM

Patient Last Name | Patient First Name | Date of Birth

Social History:

Tobacco Use Y **Please explain below** N **No and have never**

		Packs per day / How often?	Years of use?			Packs per day / How ofen?	Years of use?
Cigarettes	Y N			Cigar	Y N		
Pipe	Y N			Chewing Tobacco	Y N		

Do you drink alcohol Y N

Occasionally
Daily
Beer / Wine
Hard Liquor

Choose One
Marital Status

Occupation:

Family History:	Alive	Age	List Illnesses or Cause of Death
Mother	Y N		
Father	Y N		
Siblings (brother/sister)	Y N		
Other	Y N		

Are you allergic to any medications? Y N

Please List:

Medications: List all medicines and supplements you take:

Medication	Start Date	Dose	How often?	Reason

continue >

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PATIENT COMMUNICATION DESIGNATION

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Last Name | Patient First Name | Date of Birth

Street Address | City | State | Zip Code | Social Security Number (optional)

Primary Contact Number | Medical Record Number

If we cannot reach you at the telephone number listed above, WellStar may contact you including leaving messages regarding appointments or normal lab results at the following number(s):

Home Telephone ☐ Check if primary.

Work Telephone ☐ Check if primary.

Mobile Number ☐ Check if primary.

I authorize WellStar Health System to disclose Protected Health Information to the following persons:

☐ **Spouse:** Name | Phone Number

☐ **Child(ren):** Name | Phone Number

Name | Phone Number

☐ **Other:** Name | Phone Number

Information to be disclosed:

☐ All medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.

Signature / Date: (date authorization signed by Patient or Legal Guardian / Personal Representative) | Date

Print Patient Name or Name of Legal Guardian / Personal Representative | Signature of Patient or Legal Guardian / Personal Representative

Indicate relationship to Patient (required)

Expiration Date:
This authorization is valid until written notice is provided to revoke this authorization.

NGOC NORTHWEST GEORGIA ONCOLOGY CENTERS

Wellstar HEALTH SYSTEM
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Patient Registration Form

MEDICATION LOG

Use this form to keep a record of all prescribed medications. Talk to your provider or your pharmacist if you have any questions regarding your medications or if you're experiencing unexpected complications or side effects.

- If medication or treatment prescribed by your physician doesn't seem to help the problem, please let your provider know.
- Please check your medications at the beginning of each week to make sure you will have enough until your next visit.
- Please allow a 24 hour notice for prescription refills.
- Pain medications require a written prescription from your physician and cannot be refilled on weekends or after office hours.

PATIENT INFORMATION

Patient Last Name | Patient First Name | Date of Birth

Date form completed:

1

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

2

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

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Patient Registration Form

MEDICATION LOG

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Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

4

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience

5

Medication Name | Prescription Number

Date Prescribed | Prescribing Doctor

Dosage | Date Started | Date Ended

Reason Prescribed

Notes

Side Effects experience